center for vital health

PATIENT INFORMATION-**Please print**

Name_____Goes by_____
First MI Last

Mailing Address_____
Street Address /PO Box City State Zip

Social Security #_____Birth Date_____ Spouse/Partner name_____

Partner status: Single Married Divorced Widow/er Separated Patient's sexual identity_____

Employer_____Phone # (_____) _____

Emergency Contact_____Phone # (_____) _____

How did you hear about our office?_____

INSURANCE INFORMATION We do not file insurance. We will give you the superbill to submit to your insurance.

Do you have **Medicare**? Y N Do you have **Medicaid**? Y N Is this related to a **Motor Vehicle Accident** Y N

RELEASE OF INFORMATION

Daytime Phone # (____)_____Ok to leave a voice message? Yes No

Email Address_____Ok to send email? Yes No

Is there anyone else that we can talk to about your medical care or who may call on your behalf?

Name_____Telephone #_____

PLEASE INITIAL:

_____I understand there is a $50 fee for appointments not canceled 24 hours in advance.

_____I understand there is a 70% fee for Prolo/PRP appointments not canceled 48 hours in advance.

_____I understand that there is a $50 return check fee

_____I understand that Dr. Harrow will not accept assignment from my insurance company.

_____I understand that Dr. Harrow is only on-call for patients who have had a procedure in the office. All other patients need to call during business hours or contact urgent care.

_____I understand that neither Dr. Harrow nor any staff member will communicate with my insurance company about claims I submit.

All of the above statements are true and correct. I understand that I am responsible for payment on my account.

X_____
Signature Date

HEALTH HISTORY

Name _____ Date of Birth _____ Today's Date _____

Occupation _____Age_____ Height _____ Gender _____ Number of Children _____

Marital Status: ❒ Single ❒ Partner ❒ Married ❒ Separated ❒ Divorced ❒ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit Date began

_____ _____

_____ _____

Date of last physical exam _____ Practitioner name and phone number _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis)

_____

Outcome _____

What types of therapy have you tried for this problem(s)?

❒ Diet modification ❒ Fasting ❒ Vitamin/mineral ❒ Herbs ❒ Homeopathy ❒ Chiropractic ❒ Acupuncture ❒ Conventional drugs

❒ Other _____

List current health problems for which you are being treated: _____

_____

Current medications (prescription or over-the-counter): _____

_____

Major hospitalizations, surgeries, injuries: Please list all procedures, complications (if any) and dates:

Year	Operations, illness, injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ❒ underweight ❒ overweight ❒ just right Your weight today _____

❒ Unintentional weight loss or gain of 10 pounds or more in the last three months

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)? _____

❒ Corrective lenses ❒ Dentures ❒ Hearing Aid ❒ Medical devices/prosthetics/implants, describe: _____

Do you experience any of these general symptoms EVERYDAY?

❒ Debilitating fatigue	❒ Shortness of breath	❒ Insomnia	❒ Constipation	❒ Chronic pain/inflammation
❒ Depression	❒ Panic attacks	❒ Nausea	❒ Fecal incontinence	❒ Bleeding
❒ Disinterest in sex	❒ Headaches	❒ Vomiting	❒ Urinary incontinence	❒ Discharge
❒ Disinterest in eating	❒ Dizziness	❒ Diarrhea	❒ Low grade fever	❒ Itching/rash

Medical History

- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer _____
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophogeal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins

Other _____
_____

Medical (Men)

- ☐ BPH
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ STD

Other _____
_____

Medical (Women)

- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ PMS
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ STD

Other _____
Age of first period _____
Date of last gynecological exam __
Mammogram ❒+ ❒ -
PAP ❒+ ❒ -
Form of birth control _____
Number of children _____
Number of pregnancies _____

- ☐ C-section _____
- ☐ Surgical menopause
- ☐ Menopause

Date of last menstrual cycle _____
Length of cycle _____ days
Interval of time between cycles ___ days
Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)? _____

Family Health History (parents and siblings)

- ☐ Arthritis, rheumatoid
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer _____
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

Other _____

Health Habits

- ☐ Tobacco:

Cigarettes: #/day _____
Cigars: #/day _____

- ☐ Alcohol:

Wine: # glasses/d or wk _____
Liquor: #ounces/d or wk _____
Beer: #glasses/d or wk _____

- ☐ Caffeine:

Coffee: #6 oz cups/d_____
Tea: #6 oz cups/d _____
Soda w/caffeine: #cans/d _____
Other sources _____

- ☐ Water: #glasses/d _____

Exercise

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk
- ☐ Run, jog, bike, jump rope
- ☐ Weight lift
- ☐ Swim
- ☐ Box
- ☐ Yoga

Nutrition & Diet

- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction
- ☐ Specific food restrictions:

❒dairy ❒wheat ❒eggs
❒soy ❒corn ❒all gluten
Other _____

Food Frequency

Servings per day:
Fruits (citrus, melons, etc.) _____
Dark green or deep yellow/orange vegetables _____
Grains (unprocessed) _____
Beans, peas, legumes _____
Dairy, eggs _____
Meat, poultry, fish _____

Eating Habits

- ☐ Skip breakfast
- ☐ Two meals/day
- ☐ One meal/day
- ☐ Graze (small frequent meals)
- ☐ Food rotation
- ☐ Eat constantly - hungry or not
- ☐ Generally eat on the run
- ☐ Add salt to food

Current Supplements

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening Primrose/GLA
- ☐ Calcium, source_____
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals, describe _____
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g. lutein, resveritrol, etc.)
- ☐ Herbs – teas
- ☐ Herbs – extracts
- ☐ Chinese herbs
- ☐ Ayurvedic herbs
- ☐ Homeopathy
- ☐ Bach flowers
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals (e.g., Ensure)

Other_____

Would you like to:

- ☐ Have more energy
- ☐ Be stronger
- ☐ Have more endurance
- ☐ Increase your sex drive
- ☐ Be thinner
- ☐ Be more muscular
- ☐ Improve your complexion
- ☐ Have stronger nails
- ☐ Have healthier hair
- ☐ Be less moody
- ☐ Be less depressed
- ☐ Be less indecisive
- ☐ Feel more motivated
- ☐ Be more organized
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Do better on tests in school
- ☐ Not be dependent on over-the-counter medications like aspirin, Tylenol, Benadryl, sleeping aids, etc.
- ☐ Stop using laxatives or stool softeners
- ☐ Be free of pain
- ☐ Sleep better
- ☐ Have agreeable breath
- ☐ Have agreeable body odor
- ☐ Have stronger teeth
- ☐ Get less colds and flus
- ☐ Get rid of your allergies
- ☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

center for vital health, inc.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective Date of this Notice: 04/14/2003

With my consent, Center for Vital Health, Inc. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Center for Vital Health, Inc.'s *Notice of Privacy Practices* for a more complete description of such uses and disclosures.

I have the right to review the *Notice of Privacy Practices* prior to signing this consent. Center for Vital Health, Inc. reserves the right to revise the *Notice of Privacy Practices* anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Center for Vital Health, Inc. at Center for Vital Health, Inc., 1485 Garden of the Gods Road, Suite 172, Colorado Springs, CO 80907.

With my consent, Center for Vital Health, Inc. may mail to my home, or other designated location, any item that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements; as long as they are marked 'Personal and Confidential.'

I have the right to request that Center for Vital Health, Inc. restrict how the practice uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Center for Vital Health, Inc.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice had already made disclosures in reliance upon my prior consent. If I do not sign this consent, Center for Vital Health, Inc. may decline to provide treatment to me.

_____ _____

Date Patient's Signature (parent/legal guardian if under 18)

_____

Patient's Printed Name

THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Medical Symptoms Questionnaire (MSQ)

Patient Name_____ Date_____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale

0 – ***Never or almost never*** have the symptom
1 – ***Occasionally*** have it, effect is ***not severe***
2 – ***Occasionally*** have it, effect is ***severe***
3 – ***Frequently*** have it, effect is ***not severe***
4 – ***Frequently*** have it, effect is ***severe***

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

Total _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(Does not include near or far-sightedness)

Total _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss

Total _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation

Total _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores

Total _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating

Total _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain

Total _____

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing

Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain

Total _____

JOINTS/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness

Total _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight

Total _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness

Total _____

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities

Total _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression

Total _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge

Total _____

Grand Total _____

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

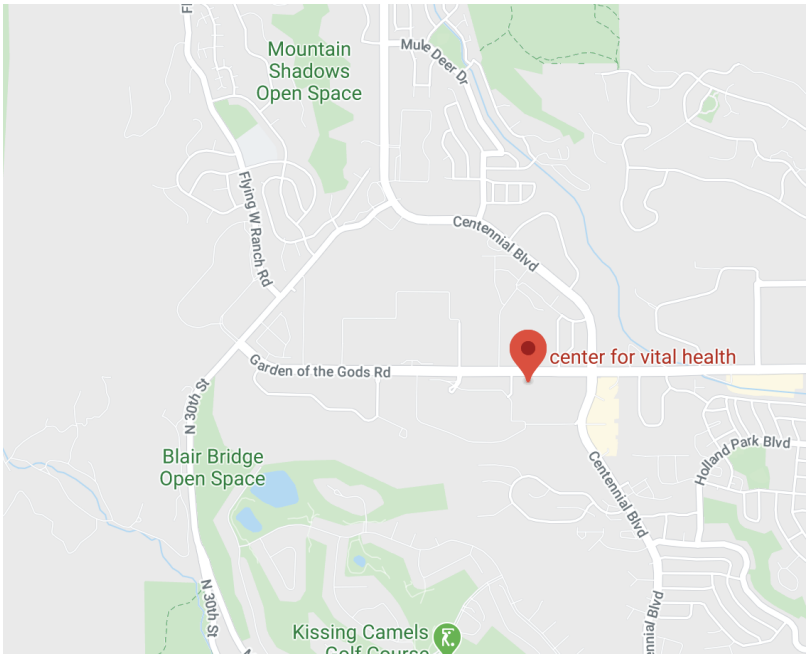
center for vital health, inc.

DIRECTIONS TO OUR OFFICE

center for vital health inc.
1485 W Garden of the Gods Road
Suite 172
Colorado Springs, CO 80907
719.531.6778

Westbound:

From I-25 : Exit West on Garden of the Gods Road, make a U-turn at the second left after Centennial (you will then be heading East). Turn right right into our parking lot. Our office is located on the West side of the brown stucco building with black glass. You will see Farmers Insurance Company in the front of the complex. Across the street will be Trinity Brewing, Sherwin Williams and Kum & Go



Eastbound:
Heading East on Garden of the Gods Rd, we are the fifth right off of Garden of the Gods, a block past the county building.

Landmarks :
We are located across the street from a complex with Sherwin Williams Paint Store and Trinity Brewing Company.